健康診断書

CERTIFICATE OF HEALTH (to be completed by the examining physician)

日本語又は英語により明瞭に記載すること。
Please fill out (PRINT/TYPE)in Japanese or English.

氏名
Name : _____ , _____
Family name, First name Middle name

□男 Male □女 Female

生年月日
Date of Birth :

年齢
Age :

1．身体検査
Physical Examinations

(1) 身 長 Height_____cm　体 重 Weight_____kg

(2) 血 圧
Blood pressure_____mm/Hg～_____ mm/Hg

血液型 Blood Type | ABO | RH +/−

脈拍 Pulse □整 regular □不整 irregular

(3) 視 力
Eyesight : (R)_____ (L)_____
裸眼 without glasses

色覚異常の有無 color blindness □正常 normal □異常 impaired

(4) 聴 力 Hearing : □正常 normal □低下 impaired

言 語 speech : □正常 normal □異常 impaired

2．申請者の胸部について，聴診とX線検査の結果を記入してください。X線検査の日付も記入すること（6ヶ月以上前の検査は無効。）
Please describe the results of physical and X-ray examinations of applicant's chest x-ray (X-ray taken more than 6 months prior to the certification is NOT valid).

肺 lung : □正常 normal □異常 impaired

心臓 Cardiomegaly : □正常 normal □異常 impaired

↓

異常がある場合 心電図 Electrocardiograph : □正常 normal □異常 impaired

Describe the condition of applicant's lung.

3．現在治療中の病気 Disease Treated at Present □Yes (Disease:_____) □No

4．既往症
Past history : Please indicate with + or − and fill in the date of recovery

Tuberculosis.....□(. .) Malaria.....□(. .) Other communicable disease.....□(. .)
Epilepsy.....□(. .) Kidney Disease.....□(. .) Heart Diseases.....□(. .)
Diabetes.....□(. .) Drug Allergy.....□(. .) Psychosis.....□(. .)
Functional Disorder in extremities.....□(. .)

5．検 査 Laboratory tests
検 尿 Urinalysis:glucose ( ),protein ( ),occult blood ( )

赤沈 ESR :_____mm/Hr, WBC count :_____/cmm 貧血 anemia □

Hemoglobin:_____gm/dl, GPT:

6．診断医の印象を述べて下さい。
Please describe your impression.

7．志願者の既往歴，診察・検査の結果から判断して，現在の健康の状況は充分に留学に耐えうるものと思われますか？
In view of the applicant's history and the above findings, is it your observation his/her health status is adequate to pursue studies in Japan ?
yes □ no □

日付 Date: _____ 署名 Signature:_____

医 師 氏 名
Physician's Name in Print:_____

検査施設名
Office/Institution:
所在地
Address:_____

Please turn over.

The following questions are completed by the physician.

(1) Has the participant previously been hospitalized? Yes☐ No☐
If yes, when and for what reason.

(2) Will the participant require any ongoing medication or treatment for any particular condition during the program ? Yes☐ No☐
If yes, explain.

(3) Any previous nervous or eating disorders? Yes☐ No☐
If yes, explain.

(4) Any physical limitations that could prevent them from normal activities such as sports, etc. Yes☐ No☐
If yes, explain.